DBT SKILLS IN EVERYDAY LIFE FOR FAMILY PHYSICIANS AND UPDATE ON EATING DISORDERS

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FACULTY/PRESENTER DISCLOSURE : DR. MARYNA MAMMOLITI

- Co-founder of coaching and educational company: Triumph Excellence And Coaching Centre Ltd
- Financial compensation: OHIP, hospital stipends, IME work for various third parties (i.e. Seiden, Dynamic Solutions, RIDM etc) , speaking fees for various presentations (non-pharmaceutical payments)
    - **Grants/Research Support:** none

OBJECTIVES

1) Discuss DBT skills for everyday practice in primary care.

2) Discuss DBT skills for Personal Life and Conflict Resolution.

3) Discuss update for Eating Disorders in primary care.

DBT- DIALECTICAL BEHAVIOR THERAPY

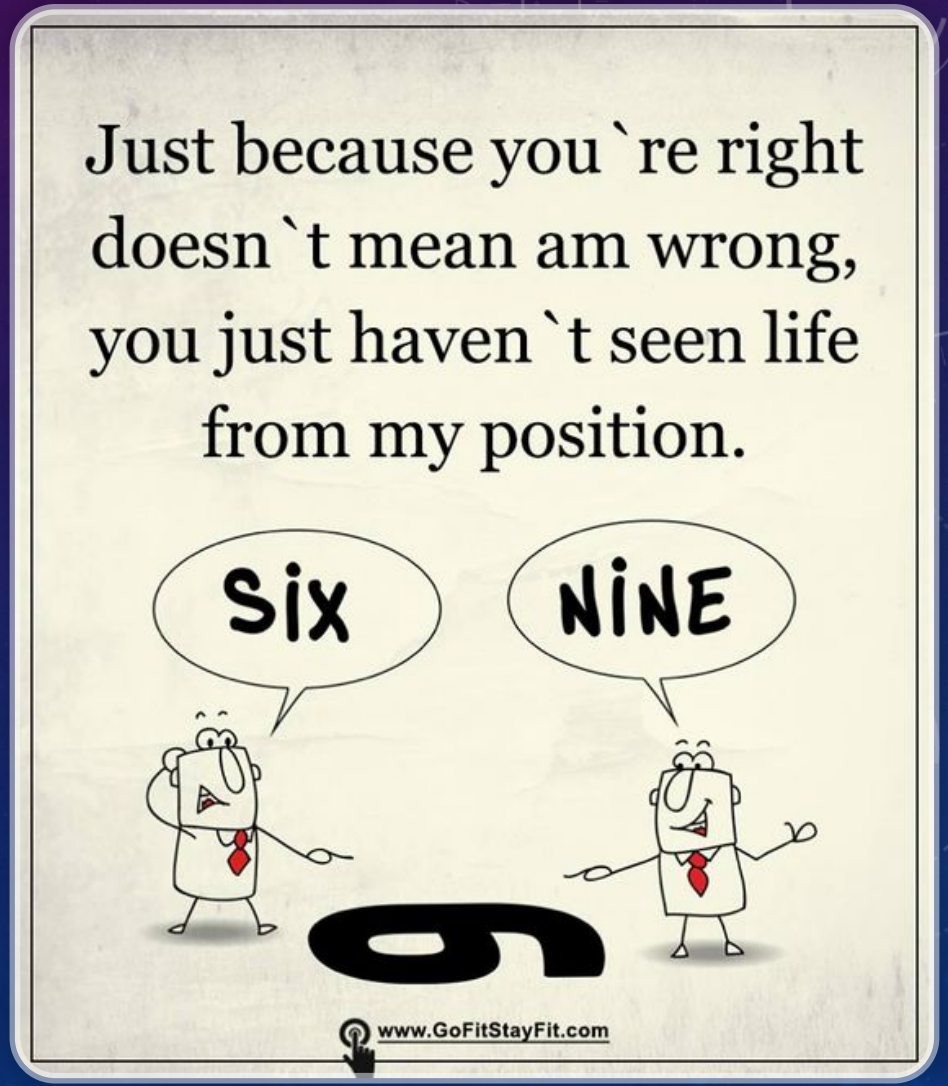
- Created by Marsha Linehan (psychologist) originally for treatment of Borderline Personality Disorder but now adapted for many other areas
- 4 areas of SKILLS:
- Mindfulness
- Distress Tolerance
- Emotional Regulation
- Interpersonal Effectiveness

FOUNDATION:

- DIALECTICS – OPPOSITES ARE TRUE AT THE SAME TIME
- ACCEPTANCE AND CHANGE
- YOUR LIFE IS HARD AND IT IS UP TO YOU TO FIX IT
- PAIN AND DISAPPOINTMENT IS PART OF LIFE
- VALIDATION AND SELF-VALIDATION
- DBT teams have 24/7 availability and therapists work as a team to support clients
- AND instead of a BUT

OPPOSITES ARE TRUE AT THE SAME TIME

- Opposites can be true at the same time (ie your version and completely opposite version can be true at the same time); different is NOT wrong – it is just different
- You are right AND the other person is right
- Your life is hard and it is up to you to change it
- NO BUTS, AND is your BRIDGE and CONNECTION



VALIDATION

- YOUR MOST POWERFUL TOOL IN LIFE

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- **VALIDATION** – accepting what you/other person feels and thinks as right, logical and reasonable for you/them (maybe totally unreasonable for another person)
- We validate thoughts and feelings NOT actions/behaviors
- i.e. I'm okay to feel angry and upset given my life experience; I can see how frustrating/frightening this could have been for you/I can't imagine what's it like to be in that situation
- Avoid **INVALIDATION** (all those coulds, shoulds, at least comments, WHY questions) (telling yourself or others that what they feel/ think is wrong, invalid and shouldn't be that way)
- I.e. why are you anxious? What's the big deal? I shouldn't feel this way, why would you be scared of that – that's ridiculous

VALIDATION LEVELS

- 1) Level 1: Be present and appear interested
- 2) Level 2: Reflect (i.e. I hear you saying etc)/ Paraphrase (thoughts, emotions)
- 3) Level 3: Put yourself in their shoes/ Mind Read (what maybe unexpressed emotions, thoughts)
- 4) Level 4: Validate based on history/ Make Sense based on past (thoughts, behaviors, experiences, biological differences)
- 5) Level 5: Validate based on current situation/Normalize what is true for most people
- 6) Level 6: Radical genuiness – treat patient/peer/friend as an equal, effective human

DBT SKILLS: MINDFULNESS

- MINDFULNESS: present here and now NONJUDGEMENTALLY
- Blending of emotional and reasonable mind to stay in the WISE MIND
- WHAT SKILLS: OBSERVE, DESCRIBE, PARTICIPATE (what you do to be mindful)
- HOW SKILLS: (how you do the WHAT skills) NON JUDGEMENTALLY, ONE-MINDFULLY, EFFECTIVELY

DBT SKILLS: EMOTIONAL REGULATION

- Understanding emotions
- Identify and label emotions, acknowledging and tolerating emotions
- Reduce vulnerability with ABC STRONG (Accumulate Positives, Build Mastery, Cope Ahead, Sleep, Treat physical Illess, Resist Drugs, Once a day do something that gives you feeling of being in control, Nutrition, Ger Exercise)
- Check the FACTS, behavioral chain analysis , problem solving, Pros and Cons,
- Validation: acknowledging, allowing, understanding – several levels of validation
- 4 Options for problems: tolerate the problem, change your belief, solve the problem, stay miserable

DBT SKILL: DISTRESS TOLERANCE

- Tolerating painful emotions (not avoiding)
- Distracts with ACCEPTS (Activities, Contributing, Comparisons, Emotion opposites, Pushing Away, Thoughts, Self Sooth with activities)
- Self-sooth (use 5 senses, grounding skills)
- IMPROVE the moment (Imagery, Meaning, Prayer, Relaxation, One thing at a time, Vacation, Encouragement)
- Pros and CONS
- Radical Acceptance
- TIP skills (temperature, intense exercise, progressive muscle relaxation paced breathing)
- STOP (stop what you are doing, take some deep breath, Observe the situation, Proceed effectively)
- OPPOSITE action

DBT SKILLS:INTERPERSONAL EFFECTIVENESS

- Managing Interpersonal interactions
- Focuses on communication styles and building assertiveness, boundaries
- DEARMAN (Describe, Express, Assert, Reinforce, Mindful, Appear Confident, Negotiate)
- GIVE (Gentle, Interested, Validate, Easy Manner)
- FAST (Fair, Apology free, Stick to values, Truthfulness)

DBT SKILLS FOR EVERYDAY IN PRIMARY CARE

- Your Patient is trying the best she/he can **at the same** time you need to have boundaries
- Cannot rescue – you can be there to support them – they need to initiate change
- YOU cannot RESCUE patients – that takes away their autonomy and promotes the patriarchal approach (unless they are incapable and emergencies etc)

DBT SKILLS FOR PERSONAL LIFE AND CONFLICT RESOLUTION

- Using DBT skills in personal life: within personal and professional relationships
- VALIDATION
- MINDFULNESS to reduce burnout and emotional content of work/ what we carry from patient encounters
- Dealing with colleagues/conflict
- EMOTIONAL REGULATION

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DBT SKILLS WITH PEERS: VALIDATION, NON-JUDGEMENTAL STAND, EMOTIONAL REGULATION

- YOU ARE RIGHT and VALID in your clinical concern AND your colleague may be right in opposite clinical opinion and instead of trying to prove who is MORE right – try to understand the other person's view/perspective or show them yours
- IF ONE IS RIGHT =THE OTHER ONE IS RIGHT FROM THEIR PERSPECTIVE
- DIFFERENCE IS NOT DEFECT (you are okay to have your coffee black AND your colleague is okay to have it with milk – we don't argue which is the more right way to have coffee) yet we forget that in medicine we all come with different backgrounds/ knowledge/experience/training/knowledge of the patient even in the same specialty
- I statements

WHEN THEY GO LOW, WE GO HIGH- MICHELLE OBAMA

- Engaging in arguing/"guns ablazing", "I will show you", "Who is your CHIEF", "WELL did you know CPSO .." =REACTIVE behavior….will cause "secondary events" that will cause even more emotions and consequences
- Example: the consultant is not listening or being judgemental towards you (you feel angry, rightfully so..and you act out of anger) and write an email to their chief stewing on it for days..to find out later that this consultant has a child with recently diagnosed cancer ==now the email was the secondary event and now you are stewing in guilt
- If the other PEER is invalidating you/judging you/criticizing you – validate them and your position "I understand as a pediatrician this maybe a very easy/straight forward case AND/AT THE SAME TIME for me as a psychiatrist I was worried as I do not manage these cases in my role and that is why I sent them in hoping for your expertise and care for Bobby" –right there a reasonable person on the other side will realize and engage in corrective behavior – if they are not reasonable or oblivious they will continue bashing etc – THEIR BEHAVIOR tells you about them/their ability to reflect on the interaction – THEIR BEHAVIOR is not a reflection of your "weakness/lack of knowledge" or being weak – WALK AWAY from an ignorant person – your breath takes thousands of molecular reactions to happen – do not waste your breathe on peer arguments that resolve nothing – WALKING AWAY after realizing that your peer cannot understand your perspective/position/experience saves your breath/energy (of course as long as patient safety is NOT compromised, PATIENT SAFETY trumps all)

EXAMPLES WITH PEERS

- “I understand that to you, an internist, a blood pressure of 180/90 may not be concerning AT THE SAME time to me as a psychiatrist this is concerning as I do not treat blood pressure every day and I am hoping you can help me out”
- I can’t imagine how busy your department/list is today AND I would like to help you with this consult – I just have about 30 patients to see before I can get to your consult –will the patient be medically safe to wait till then? If not I would appreciate if you can manage them till I am able to get there as I cant get there before 3pm earliest”
- “I understand that from your specialist perspective/experience this may have been a simple case of jaundice – AT THE SAME TIME as a FAMILY DOCTOR in an outpatient clinic without the bloodwork and other supports and tests you can appreciate my perspective and concerns when I saw this baby in the morning and send them in for your evaluation. Thank you” (here allows a reasonable colleague to correct themselves if they were judgemental towards you – and if they don’t – their behavior tells you about them, not you”
- A consult maybe “simple” to a psychiatrist who sees cases like this everyday AND it maybe complex/hard to a Family Doctor who sees multiple other concerns and is not expected to have the same depth of experience in every single problem and it is OKAY
- “I understand this may sound simple to you as you are a surgeon AND I would appreciate your help in managing this case as for me as a psychiatrist I would not know how to manage this case”
- State their/your perspective AND their/yours AND ask/offer solutions to bring it to a close/get what you want/allow the other party to correct their behavior
- “I feel quite confused by this case AND I would appreciate your support in managing this case/ helping this patient” etc

WITH PATIENTS: VALIDATION, COLLABORATION IN PROBLEM SOLVING

- YOUR PATIENT IS RIGHT AND YOU ARE RIGHT (the patient is right in their understanding of the problem from their life experience/cultural/educational/ gender background) AND you are right from your medical training and you need to build the bridge between the opposites → "I can see how scary this rash may have been to you when you saw it appear suddenly on Monday – AND great news – it doesn't appear to be cancer and likely mostly dermatitis"; "I can't imagine how scary it felt when you had chest pain at work and passed out and thought it was a heart attack – and great news – the ECG and bloodwork are normal AND at this point it is unlikely to be a heartattack and more likely to have been a panic attack"
- "I know it may feel scary/uncomfortable AND unfortunately if we don't get the blood test/consultation it will be difficult for me to provide thorough care for you for this problem without that knowledge"
- "it sounds like you may have been frustrated with X YZ – rightfully so, who wouldn't be, AND unfortunately when someone yells/screams/threatens us - we do not feel safe proving care so how can we resolve this/what can we do about this incident"
- "I understand you are frustrated, rightfully so, AND yelling and screaming at me makes me scared and it makes it difficult for me to concentrate on your care needs so how can we start this over again so we can help you the best I can"
- "Of course it would be frustrating that I was not available (because of sick leave/ vacation/mat leave) AND I appreciate your understanding "
- "It seems like what you need I may not be able to provide AND THAT IS Okay – how should we address this?"

WITH PATIENTS

- YOUR PATIENTS expectations are VALID to them AND you may not be able to meet them within your legal/medical expertise/abilities (your patients may want MRI this week AND you may not think it is appropriate within your medical knowledge for their issue)
- YOUR PATIENT'S needs may not line up with what you can do (within reason) AND It is okay to move on to problem solving (different provider, different setting of care etc)
- YOUR GOALS are VALID AND YOUR PATIENT MAY HAVE OPPOSITE GOALS that are valid to them (you may want them to be abstinent from drug use AND your patient may not be ready/interested – accept where they are and support them within their goals within your medical judgement/expertise or arrange/transfer care to someone who can)
- YOUR PATIENT MAY HAVE EXPECTATIONS AND IT IS OKAY FOR YOU TO DISAPPOINT THEM (within reason/medico-legal obligation) such as "I understand you were hoping I would prescribe you CBD oil AND within my training/expertise/ knowledge I do not feel this is the first line treatment for your condition AND the first line treatment would be X, Y Z"
- "I can't even imagine how much you have to deal with fibromyalgia/pain/etc AND what can we focus on today/accomplishing today/addressing today"
- "Help me understand your concern with ……." "I understand your frustration with XYZ AND unfortunately this is our clinic policy"

DBT SKILLS: EMOTIONAL REGULATION

- All emotions are good and natural to us – some are stronger than others
- EMOTIONS DO NOT EQUATE TO ACTIONS – we CHOOSE how we act
- Emotions have 3 jobs: communication, motivation, validation
- 8 primary emotions : anger, sorrow, joy, fear, disgust, guilt/shame, interest, surprise
- PHYSICIANS USE TOOOOOO MUCH ISOLATION OF EMOTION (pretend that we are somehow different from others and don't feel the same emotions when there is loss, abuse, death etc)
- Some emotions are INTENSE (big hurricanes) and some are less (small waves) – they are all temporary and they resolve – we just need to identify them and ride them out
- NAME IT TO TAME IT – naming emotions helps us understand the situation and choose how to cope instead of ignoring them/supressing them
- FEELING OPPOSITE EMOTIONS AT THE SAME TIME ARE OKAY =you are happy your child is graduating school AND you are sad they are moving away
- YOU ARE HAPPY for your FRIEND AND you are JEALOUS about their promotion
- YOU ARE SAD for your patient AND you are okay to feel proud over the care you provided

MINDFULNESS

- NONJUDGEMENTAL PRESENCE IN HERE AND NOW (not the past, not the future) – focus on the here and now
- Try a mindful activity with one of your 5 senses to unload the accumulated emotions/arousal from patient encounters – after difficult patients or end of the day to transition to home
- Mindfulness decreases the “size” of the emotion so you can move from emotional to logical mind and eventually wise mind of “yes I feel guilty Ms. X has cancer AND I am okay to go home at 5pm to have dinner”
- Try activities that make sense to you – mindful eating of apple/drinking coffee/ hand soap while washing hands/coloring/music while non-judgementally describing attributes of that experience such as “I am drinking coffee, coffee is black, I smell French vanilla in the coffee” – (Not this coffee is too black, too cold, how old is this, when will I go home, I never get fresh coffee – those are all judgements) and manage to move away from other distracting thoughts
- I suggest kids’ mindfulness books as they are easier and simpler and effective (easier to remember than fancy adult books)

USEFUL SENTENCES

- Validation:
- “I can’t imagine how hard/scary/frustrating this may be..”
- “Help me understand”
- “I don’t think either one of us wanted this to happen – how should we resolve/move/address this
- “I’d like to hear what happened/Help me understand what happened”
- “what would have helped you?”
- “what do you think got in the way”
- “help me understand what got in the way of …”
- “lets brainstorm some solutions”

USEFUL SENTENCES

- “what do you see as a solution to this situation? How can I support you in this situation”
- “of course this is important to you AND let’s see what we can do within what my knowledge/expertise is/the law allows”
- “of course it is frustrating and unfortunately every health care professional in Ontario by law has to report to the MTO – I don’t have a choice – it is the law”
- “I wish I could help you more”
- “I notice/ I wonder/I wish/I hope”
- “Absolutely it is disappointing for you to hear me say no/decline etc

DISCUSS UPDATE FOR EATING DISORDERS IN PRIMARY CARE

- DSM5 FEEDING AND EATING DISORDERS
- Pica (children or adults)
- Rumination Disorder
- Avoidant/Restrictive Food Intake Disorder
- Anorexia Nervosa: Restricting type and Binge eating/purging type
- Bulimia Nervosa
- Binge Eating Disorder
- Other Specified Feeding or Eating Disorders
- Unspecified Feeding or Eating Disorder

- NON-DSM 5
- Orthorexia – obsession with healthy eating, not driven by thinness
- DIABULIMIA – eating disorder in people with type I diabetes (reduce or stop taking insulin to loo weight)

APPROACH

- 1) SCREEN EVERYONE – EAT26 an easy self-report tool
- 2) Physical Exam – Vitals, (Cardiovascular, dermatologic, Gynecologic, Gastrointestinal, Endocrine, Musculoskeletal, Neurological), BMI
- 3) Medical Investigations: CBC, lytes, BUN, Cr, fasting blood glucose, LFTs, ECG, CPK (ipecac use), amylase, Calcium, phosphorus, Magnesium, bone density, dental assessment
- 4)Medical monitoring
- 5) Referral to specialty team (LHSC in London) (psychiatric, dental, dietician, IM)

MEDICAL GOALS:

- Medical Goals (Adapted from Central West Eating Disorders Program: Putting Eating Disorders on the Radar of Primary Care Providers: Assessment Tools, Guidelines, Resources)

- Anorexia: • normalization of eating patterns • weight restoration to > 90% Ideal Body Weight (IBW) • resumption/maintenance of menses
- Bulimia: • normalization of eating patterns • cessation of bingeing, purging and excessive exercise behaviors • maintenance of a healthy, stable weight
- Binge Eating Disorder: • normalization of eating patterns • cessation of bingeing • stabilization of weight

INDICATION FOR HOSPITALIZATION: APA GUIDELINES FOR THE TREATMENT OF PATIENTS WITH EATING DISORDERS (2006)

- 1. Weight loss as defined by:
- a. 15% in one month
- b. rapid weight loss associated with physiological instability unexplained by any other medical condition
- c. weight loss associated with physiologic instability unexplained by any other medical condition
- d. patient rapidly approaching weight at which physiologic instability has occurred in the past.
- 2. BMI < 16 3. Acute refusal to eat
- 4. Heart Rate -resting daytime near 40 bpm
- 4. Blood Pressure 20 bpm or a drop in blood pressure of >10-20 mm Hg/minute from supine to standing
- 7. Hypothermic Body temp < 36°C
- 8. Syncope
- 9. Symptomatic hypoglycemia-glucose ,60mg/dl
- 10. K <2.5
- 11.Serum CL<88mmol/L
- 12.Esophageal Tears
- 13. Special Considerations: poorly controlled diabetes, pregnancy

RESOURCES FOR EATING DISORDERS

- Easy to administer in-office questionnaire: EAT-26 (Eating Attitudes Test, self-administered, score above 20 is concerning) (https://www.eat-26.com/)
- Body Brave (https://bodybrave.ca/)- available for 17+ out of Hamilton and educational resources
- Eating Disorders and ADHD – strong connection https://www.additudemag.com/webinar/eating-disorders-diagnosing-treating-podcast-358/
- EATING DISORDERS: http://www.shared-care.ca/files/Eating_Disorders_Toolkit.pdf
- Eating Disorders in Primary Care https://www.aafp.org/afp/2021/0101/p22.html
- CCI Disordered Eating Module https://www.cci.health.wa.gov.au/Resources/Looking-After-Yourself/Disordered-Eating
- https://www.nationaleatingdisorders.org/toolkit/parent-toolkit/level-care-guidelines-patients?fbclid=IwAR2cK_iF6jVoqGcLjYgC8CFIgGkiGLo8Li9DzrrQwHYm7aRTFtL7y4WoaG0]

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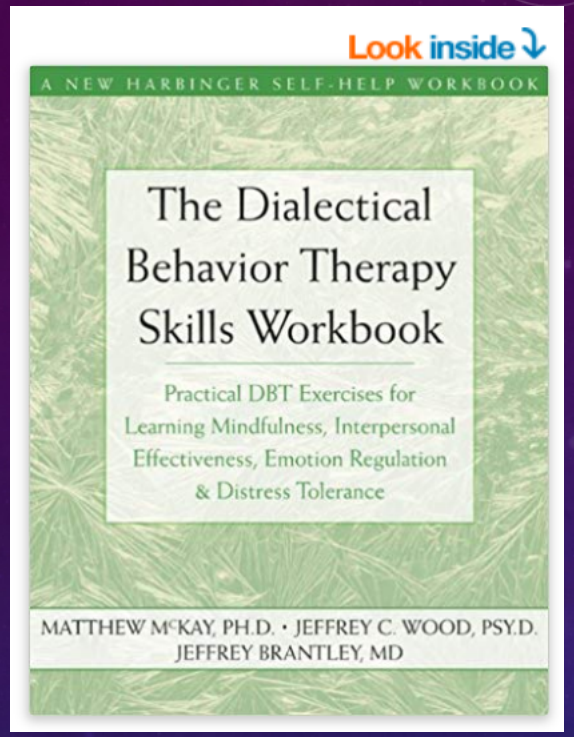
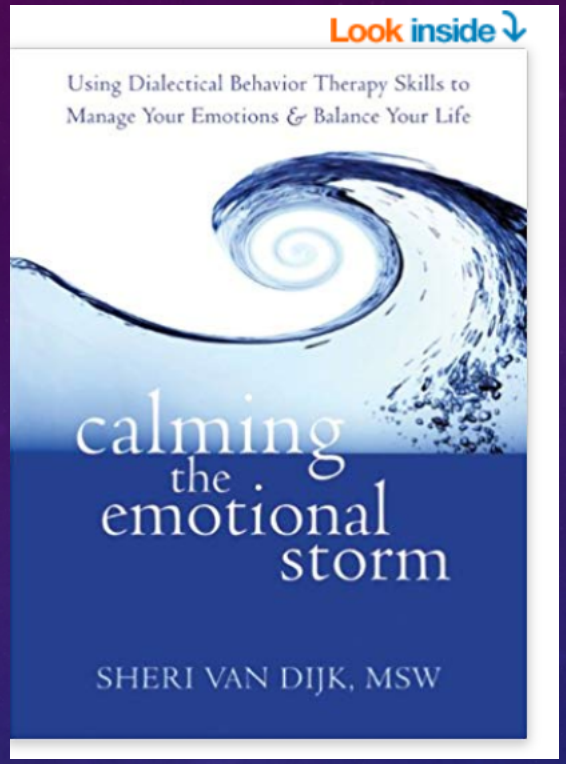
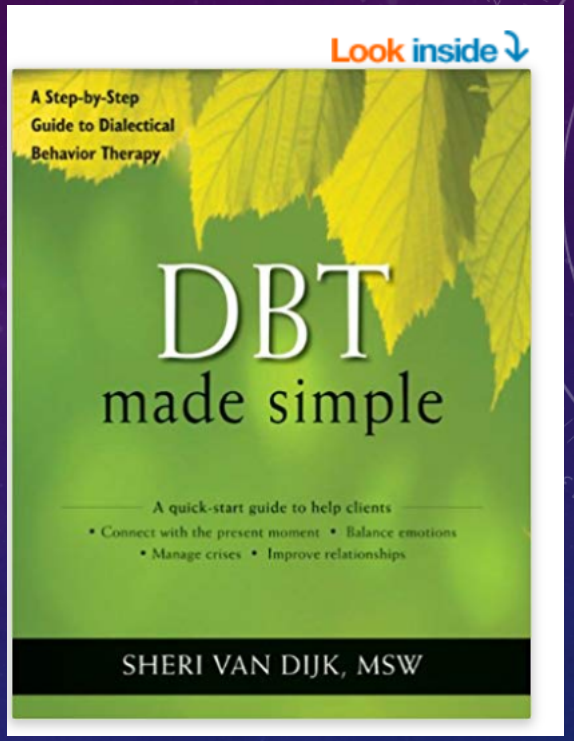
RESOURCES:

- 1) DBT training online from Marsha Linehan available at https://psychwire.com/linehan and many courses here on sale at PESI
- 2) Great website with many handouts/self guided worksheets for patients https://dialecticalbehaviortherapy.com/emotion-regulation/self-validation/
- 3) www.mindful.org
- 4) www.dbtselfhelp.com
- 5) https://www.eat-26.com/
- 6) DBT videos on youtube https://www.youtube.com/watch?v=MLnUvxg_9po
- 7) The Dialectical Behavior Therapy Skills Workbook for Anxiety: Breaking Free from Worry, Panic, PTSD, and Other Anxiety Symptoms by Chapman et al
- 8) DBT SKILLS ON YOUTUBE DBT VIDEO SKILLS https://www.youtube.com/playlist?list=PLVlLbxLe1Eo51f-BqC3u48AyikKun3mcT
- 10) MINDFULNESS SKILLS https://www.youtube.com/watch?v=NECs97k_8Z4]
- 11) Validation Review http://www.trianglereadbt.com/validation and https://psychotherapyacademy.org/dbt/six-levels-of-validation/


Look inside
A NEW HARBINGER SELF-HELP WORKBOOK
The Dialectical Behavior Therapy Skills Workbook
Practical DBT Exercises for Learning Mindfulness, Interpersonal Effectiveness, Emotion Regulation & Distress Tolerance
MATTHEW McKAY, PH.D. • JEFFREY C. WOOD, PSY.D.
JEFFREY BRANTLEY, MD


Look inside
Using Dialectical Behavior Therapy Skills to Manage Your Emotions & Balance Your Life
calming the emotional storm
SHERI VAN DIJK, MSW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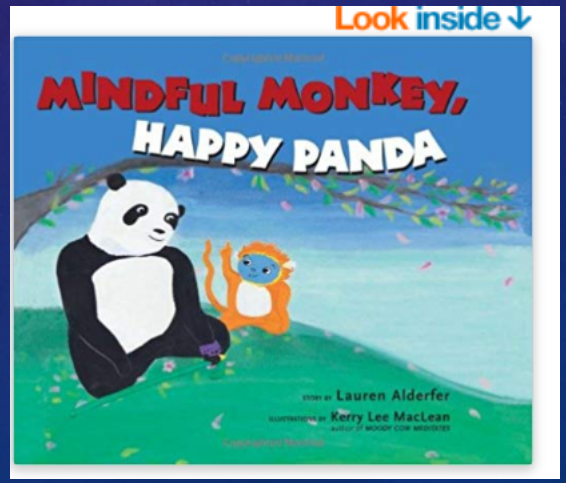
A Step-by-Step Guide to Dialectical Behavior Therapy
DBT made simple
A quick-start guide to help clients
• Connect with the present moment • Balance emotions
• Manage crises • Improve relationships
SHERI VAN DIJK, MSW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MINDFUL MONKEY, HAPPY PANDA
Lauren Alderfer
Kerry Lee MacLean